STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155753	A. BUILDING 00 B. WING	05/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON OAKS HEALTH CAMPUS	966 N WILSON RD SCOTTSBURG, IN47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Post Survey Re-visit to the Recertification and State Licensure Survey completed on April 8, 2011. Survey Date: May 31, 2011 Facility number: 004902 Provider number: 155753 AIM number: 200813130 Survey team: Avona Connell, RN TC Donna Groan, RN Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF: 18 SNF/NF: 46 Residential: 21 Total: 85 Census payor type: Medicare: 18 Medicaid: 36 Other: 31 Total: 85 Sample: 09 Residential sample: 04	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2. Quality review completed 6/3/11 Cathy Emswiller RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an allegation of misappropriation of resident property was thoroughly investigated for 1 of 3 residents reviewed for misappropriation	F0225	1. Resident #36 missing pain patch investigation was completed to include investigation with CNAs.2. All current employees were interviewed regarding the patch investigation.	06/13/2011

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	of a medication pain patch in a sample of 9. (Resident #36) Findings include: 1. The clinical record for Resident #36 was reviewed on 5/31/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to congestive heart failure and hypertension. Signed and dated Physician's Order for May 2011 included, but were not limited to: "Fentanyl (narcotic pain medication) 25mcg (micro grams)/hr (hour) TD (transdermal) patch apply 1 patch topically every 72 hrs for pain" Nurse's Notes indicated 5/14/11 10:30 a.m., "Pain patch not in place New one placed. No c/o (complaints of) pain no facial grimacing no signs of pain..." Review of the May 2011 Medication Administration Record indicated the Fentanyl patch had been applied on 5/13/11 "upon arising." During interview on 5/31/11 at 10:40 a.m., the Administrator indicated Resident #36 was missing the pain patch as it could not be found anywhere. She indicated that they suspected a Qualified Medication Aide (QMA) who was on duty at the time. One patch could not be found		5 residents currently have pain patches and continue to be checked for placement every shift by licensed staff. Tegaderm and/or tape is utilized to reinforce the patch to prevent dislodgement. 3. The ED and DHS were re-educated regarding the expectation of for thorough investigating in compliance with this regulation to include interviewing CNAs. A follow-up meeting on 6/9/11 was held with the local police investigator in an attempt to identify a perpetrator. All Nursing staff were re-educated to review concerns of missing and/or dislodged pain patches and the importance of reporting immediately when identified as missing.4. Home Office Support staff will review any future investigations conducted by the ED and/or DHS to ensure thorough investigation, to include interviewing pertinent staff. In addition, these investigations will be checked during the monthly campus visit conducted by the Home Office Support. These audits will continue a minimum of 6 months. Results will be reviewed in monthly QA meeting, and if 100% compliance is not reached for 3 consecutive months, monthly audits will continue until this threshold is met.	

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	on the resident or clothing. Another resident's missing patch was found in their clothing. On 5/31/11 at 1:08 p.m., in interview with the Administrator, she indicated the Certified Nursing Assistants (CNA) were not interviewed as part of the investigation into the allegation of 2 (two) missing pain patches. She indicated "we didn't want to tip anyone off." We asked the nurses, if they suspected any CNA. We came in, looked @ the schedule and didn't want to tip everyone. I wanted to catch them. Documentation was lacking of a thorough investigation including the CNA's who had contact with the residents. 3.1-28(d)			
R0000		R0000		